STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155697	A. BUILDING 00 B. WING	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CLARK REHABILITATION AND SKILLED NURSING CENTER	517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00429725. Complaint IN00429725 - No deficiencies related to the allegations are cited. Survey dates: April 1, 2, 3, 4, and 5, 2024. Facility number: 000059 Provider number: 155697 AIM number: 100266560 Census Bed Type: SNF/NF: 7 SNF: 61 Total: 68 Census Payor Type: Medicare: 7 Medicaid: 47 Other: 14 Total: 68 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on April 15, 2024.	F 0000		
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review, and	F 0677	**F677 ADL Care Provided for**	05/01/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Holly Bricker	Executive Director	04/26/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	interview, the facility failed to ensure showers were provided consistently for 2 of 4 residents reviewed for Activities of Daily Living care. (Residents 19 and 67) 1. The record for Resident 19 was reviewed on 4/1/24 at 11:03 a.m. The resident's diagnoses included, but were not limited to, sepsis, muscle weakness, vascular dementia, personal history of traumatic brain injury, anxiety, flaccid hemiplegia affecting the left nondominant side and bipolar disorder. The care plan, dated 8/5/18 and revised on 2/20/24, indicated the Resident required assistance with ADLs (activities of daily living) included bed mobility, transfers, eating and toileting. The interventions included, but were not limited to, assist with oral care at least two times daily, and assist with bathing as needed per resident preference. Staff were to offer the resident's showers two times per week and provide a partial bath in between. The Quarterly MDS (Minimum Data Set) assessment, dated 2/15/24, indicated the resident was severely cognitively impaired. He was dependent on staff for his oral hygiene and bathing. The residents shower schedule indicated the following: - January 4 through January 31, 2024, the resident did not have a shower. - February 1 through February 29, 2024, the resident had a shower on 2/9/24 and 2/23/24. There were no other documented showers for the month of February.		**Dependent Residents** Based on observation, record review and interview, the facility failed to ensure showers were provided consistently for 2 of 4 residents reviewed for Activities of Daily Living Care. (Residents 19 &67) 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**. Residents #19 & 67 have not had any ill effects from the alleged deficient practice. Residents #19 and 67 are receiving showers per resident preference. 2. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken** All other dependent residents have the potential to be affected by the alleged deficient practice. All other dependent residents shower sheets were audited/reviewed and care plans updated according to preference. Nursing staff were in serviced on providing showers per resident schedule/preference consistently.	

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	- March 1 through March 30, 2024, the resident had a shower on 3/22/24. There were no other documented showers for the month of March. During an interview on 4/5/24 9:25 a.m., LPN (Licensed Practical Nurse) 5 indicated the resident should have received a shower two times a week. The only reason a resident wouldn't receive a shower was if they were out of the facility or the resident refused. 2. During an observation on 4/1/24 at 11:36 a.m., Resident 67 was observed with a soiled brief, dried, peeling skin on his mouth and lips, and his teeth had a thick crusty yellowish buildup. The resident only had a tee shirt and a soiled brief. He was not covered and there was a strong urine odor. The resident's record was reviewed on 4/1/24 at 11:06 a.m. The diagnoses included, but were not limited to, nontraumatic intracerebral hemorrhage, aphasia, dysarthria and dysphagia following a nontraumatic intracerebral hemorrhage, abnormalities of gait and mobility, and dorsalis. The Quarterly MDS assessment, dated 2/22/24, indicated the resident was severely cognitively impaired. He was dependent on staff for his oral hygiene and bathing. The care plan, dated 2/20/24, indicated the resident required assistance with ADLs (included bed mobility, transfers, eating and toileting. The interventions included, but were not limited to, assist with oral care at least two times daily, and assist with bathing as needed per resident preference. Staff were to offer the resident's showers two times per week, and a partial bath in		3. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Nursing staff were in-serviced on providing showers per resident schedule consistently & documentation IDT team/designee will initiate daily shower sheets for CNA's with their assigned showers for the day Daily rounds on all shifts to ensure residents received showers per schedule. IDT team/designee to audit Shower schedule with shower sheets received daily to ensure all residents have received their showers per preference/schedule. IDT team/designee to do daily rounds with residents to ensure they have received their shower per schedule/preference. IDT team/designee to update resident profile/care plan as needed **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place.** DNS/designee will conduct audits using the Accommodation of Needs (ADL: Showers, bed bath per preference) QAPI tool weekly x 8 weeks, monthly x 6 months	

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	between. The residents shower documentation indicated for the months of February and March the resident did not receive a shower. During an interview on 4/4/24 at 1:49 p.m., CNA (Certified Nurse Aide) 8 indicated the resident was supposed to take his showers on the evening shift. She indicated the resident was able to get up in a chair. There would be no reason he could not take a shower. During an interview on 4/4/24 at 2:00 p.m., CNA 9 indicated she was able to complete her resident showers. Sometimes they would get backed up, but they usually got done. Sometimes the residents would refuse a shower and they didn't always get a chance to get back to to them. They were able to stay on schedule most of the time. If they had a refusal or hospice came in to give a hospice resident their bath they would go back and ask the resident that refused if they were ready to take their shower. The residents should receive two showers a week. The facility did not present a policy for Activities of Daily Living. 3.1-38(a)(3)		and quarterly x 2 quarters. Audit tool results to be reviewed Monthly at QAPI meeting. If 95% compliance is not achieved, an action plan will be implemented. **5. By what date the systemic changes for each deficiency will be completed?** May 1, 2024 **Attachments A,B,C,D,E**	
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is			

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	unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based on observation, interview, and record review the facility failed to ensure a splint device was provided to prevent a decrease in range of motion for 1 of 3 residents reviewed for range of motion. (Resident 40) Findings include: The record for Resident 40 was reviewed on 4/3/24 at 2:07 p.m. The resident's diagnoses included, but were not limited to, hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting the left non-dominant side, spastic hemiplegia affecting the left nondominant side, attention and concentration deficit following cerebral infarction, spastic hemiplegia affecting left dominant side, muscle weakness, and need for assistance with personal care. The care plan, dated 9/13/19, indicated the resident required assistance with ADLs (Activities of Daily Living) including bed mobility, and transfers related to a decrease in strength and an increase in weakness, and a CVA (cardiovascular accident) with left sided hemiplegia. The interventions, dated 11/12/19, included, but were not limited to, apply the LUE	F 0688	**F688 Increase/Prevent Decrease in ROM/Mobility** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident #40 no longer as order for splint Residents #40 have not had any ill effects from the alleged deficient practice. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents with recommendations for splints have the potential to be affected by the alleged deficient practice. An audit was completed to identify all residents with recommendations for splints, and ensure that devices have physician orders, are care planned	05/01/2024

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	(left upper extremity) hand splint up to two hours per day and a LUE elbow splint up to six hours per day as tolerated. The physician's order, dated 6/27/22, indicated the resident was to wear a resting hand splint to her left hand for two to four hours per day as tolerated and to perform PROM (passive range of motion) to the left hand prior to the splint placement once a day from 7:00 a.m. to 11:00 a.m. The Quarterly MDS (Minimum Data Set) assessment, dated 7/25/23, indicated the resident was cognitively intact. She was dependent on staff for upper and lower body dressing, putting on footwear, and showering. The Annual MDS assessment, dated 12/15/23, indicated the resident was cognitively intact. During an observation on 4/1/24 at 9:50 a.m., the resident was sitting in her wheelchair. There was no splint on her left hand. She indicated it was in her drawer and she pulled it out of the drawer to show where it was. During an observation on 4/2/24 at 10:24 a.m., the resident's brace was not on her left arm and hand. She indicated if staff would assist her to put the brace on her, she would wear it. The resident's left hand was contracted. During an observation and interview on 4/4/24 at 10:25 a.m., the resident indicated it had been a while since the brace had been applied to her arm and hand, and it had been at least six months. She thought she was supposed to wear it for about six hours. She got the brace about a year ago. Therapy didn't work with her much now. The brace held her arm and hand in place when she		for use, and are currently using the device. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** All nursing staff will be in-serviced by the DNS/Designee on splint use DNS/designee will complete daily audit to ensure residents utilizing splints have the devices available and are utilizing per order, with follow up notifications completed for any refusals. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what** DNS/designee will conduct audits using the Accommodation of Needs (Range of Motion) QA tool weekly x 8 weeks, monthly x 6 months and quarterly x 2 quarters. Audit tool results to be reviewed Monthly at QAPI meeting. If 95% compliance is not achieved, an action plan will be implemented. **5. By what date the systemic changes will be completed**: 5/1/24 Attachments D,E,F,G	

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	wore it. The resident tried to pull the Velcro straps open, but had to catch it from dropping twice. She was unable to apply the brace on her own. During an interview on 4/4/24 at 12:59 p.m., Occupational Therapist 4 indicated the resident had contractures to the left hand from a stroke prior to admission. She was not currently on case load for therapy. The resident was discharged from occupational therapy, on 1/15/24, because she met her goals and achieved her highest strength level. Splinting was included in the therapy. She had a resting splint for her hand. The splint was still ongoing and nursing staff now applied the splint. It was part of the splint placement to do ROM (range of motion) exercises. She was screened quarterly to make sure that was being done. She had not come up for the quarterly assessment yet. During an interview on 4/4/24 at 1:21 p.m., CNA (Certified Nurse Aide) 3 indicated the resident used to have a leg brace and a wrist brace. She had not seen a brace on the resident's arm. The resident was very compliant and had come a long way. During an interview on 4/4/24 at 1:23 p.m., LPN (Licensed Practical Nurse) 5 indicated the resident was total care. She transferred with a sit to stand. Restorative nursing was a different area, she didn't know about that. She had a brace and therapy was working on getting her another one. She wasn't sure about the hand brace because it was applied by restorative. During an interview on 4/4/24 at 2:01 p.m., the Corporate MDS Coordinator indicated she filled in when the MDS restorative was out. She came in only when asked to see residents. The resident			

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	had a splinting program six days weekly for her left leg and a transfer program using parallel bars six days a week. Restorative performed a wheelchair to parallel bar transfer for fifteen minutes. The splint device area was washed, and a skin assessment was conducted for the left knee. The physician's order for the arm splint was not done by restorative. She had an order for the hand splint 2 to 4 hours per day and that would be performed by the nurse. During an interview on 4/5/24 at 8:47 a.m., LPN 5 indicated she put the hand brace on the resident this morning at 7:30 a.m., after being asked questions about the splint. The order indicated the brace was to be provided for the resident 2 to 4 hours. She would also perform ROM if needed. During an interview on 4/5/24 at 9:46 a.m., LPN 6 indicated the facility had no policy for applying splints or braces. 3.1-42(a)(2)			